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Personal Experience Fact Sheet

All Personal Information is Confidential and Treated Appropriately.

PART I: BACKGROUND AND CURRENT CONCERNS

Full name: _____

Name you liked to be called: _____

Occupation: _____ Age: _____

With whom do you now live? _____

This form is intended to help me understand you, your present concerns, and your needs in our work relationship. If you have questions or if you are not clear about any of these items, please put a question mark (?) next to it and discuss it with me.

Describe the primary problem or life concern that you would like help with, include initial onset, changes in frequency and any situations/stressors (If you need additional space, please use the back of the page.)

_____

_____

_____

_____

_____

In a few words, how would you describe yourself as a person?

_____

_____

_____

_____

_____

List any other person(s) and their relationship to you (e.g., family members, friends, significant other, coworkers) who are involved in your problem(s) or concern(s) if any.

How or what are you currently doing to cope with or resolve the problem?

Have you tried any other solutions in the past? What are your coping strategies?

Are there any immediate challenges that we should deal with as soon as possible? Please note any concerns that appear urgent.

Circle and describe *any/all* of the following that accurately describe your present or recent experience.

I am now feeling or I have recently been feeling . . .

depressed or sad anxious apathetic or lethargic out of control euphoric overjoyed angry irritable or guilty or ashamed confused exhausted calm sick to my stomach jealous hopeless

aches and pains lonely numb helpless tearful or wanting to cry

I have been experiencing . . .

painful headaches trembling blurred or poor vision forgetfulness (memory loss)

losing my balance loss of appetite violent impulses sleeping problems

hearing voices chest pains feeling unreal or empty strange body sensations

mood swings dizziness hearing problems distressing dreams

unwanted thoughts feeling desperate blackouts (unconsciousness) wanting to hurt myself

seeing unreal things wanting to hurt someone drinking too much alcohol

using drugs too much wishing I were dead

Have you recently had any other feelings or experiences that you are concerned about or that might be important for me to know?

_____

_____

_____

_____

_____

What medications or supplements (prescription and otherwise) are you now taking? Please specify the purpose of each.

Medication or supplement	Daily Dose	Purpose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When was your last visit with your physician? _____

Findings from physician's visit: _____

Current Medical Conditions (diabetes, hypertension, heart problems, asthma, head trauma, cancer, etc.):

Allergies (adverse reactions to medications, food, etc): _____

Past Medical Hospitalizations/Surgeries (include dates and outcome): _____

Have you ever been in psychotherapy or seen a mental health professional before? (Circle one) Yes No

If "yes," what were the approximate dates of your treatment?

From _____ to _____

What was the primary focus of your therapy?

How helpful was it?

What did you find that was unhelpful about your therapy?

Mental Health and Chemical Dependency Treatment History:

Have you ever received treatment for psychiatric, drug or alcohol related issues? (Circle one) Yes No

If yes, please provide details:

Treatment Date	From Whom	For What	Outcome

Have you ever been Hospitalized for Mental Health reasons (Circle one): Yes No

If yes, please indicate:

Location Treatment Dates Problem Outcome

_____

_____

_____

_____

Family History of Mental Health Problems or Drug/Alcohol Abuse (Circle one) Yes No

If yes, please provide details: _____

_____

Please describe your involvement, if any, with the Legal System (criminal or civil): _____

_____

_____

_____

What Are Your Sources of Strength?

Please circle any of the following that you consider to be sources of strength for you. Feel free to add your own in the blank spaces.

my sense of humor my religious faith my patience my family my intelligence my courage my stubbornness my commitment to _____

other: _____

What are some of your coping mechanism? (How Do You Cope)?

When you are challenged or distressed by events in your life, what do you do to cope or to comfort yourself?

_____

_____

_____

How Can I Help You?

Please help me understand what you would like from me in therapy. Fill in any of the following that express your current interests. "What I would like is . . ." information about

_____ help in

understanding _____ help in

making a decision about _____

training in skills, particularly _____

support in _____

suggestions for how to solve a problem of _____

help with _____

I don't know what I want help with.

PART II: EMOTIONAL LIFE

Over the course of the last 90 days, to what extent have you experienced each of the following:

	Never →				Often
Irritability or Anger	0	0	0	0	0
Anxiety or fear	0	0	0	0	0
Enthusiasm or happiness	0	0	0	0	0
Envy or jealousy	0	0	0	0	0
Guilt	0	0	0	0	0
Hatred	0	0	0	0	0
Inner peace or tranquility	0	0	0	0	0
Joy	0	0	0	0	0
Love	0	0	0	0	0
Pride	0	0	0	0	0
Sadness or depression	0	0	0	0	0
Shame or embarrassment	0	0	0	0	0
Obsession and or compulsions	0	0	0	0	0
Sleep disturbance	0	0	0	0	0

When you were a child, which feelings or emotions were you taught to think of as "good" or "bad"?

"good" _____

"bad" _____

Which of the following expressions of emotions were *discouraged* when you were a child? (circle all that apply)

crying whining laughing pouting arguing hitting yelling swearing boasting hiding whistling make belief

touching self-rocking nail biting singing

Which emotions do you now find most difficult or uncomfortable for you?

_____

_____

How well do you remember your childhood experiences? (Circle one)

Not very well Very well
1 2 3 4 5 6 7 8 9 10

How would you describe your childhood in general? (Circle one)

Very unhappy happy Very happy

1 2 3 4 5 6 7 8 9 10

Each of the following statements describes experiences you may have had as a child. Circle all that apply to you and your childhood. Please add comments or questions in the margin. If you are not sure about an item, or if it feels too private, place a question mark next to it.

Our family life was happy. I made friends easily. I was often sick.

I trusted my parents. I felt loved and respected. I was physically beaten.

My feelings were respected. I felt trusted by my parents. I didn't have many friends.

My family moved often. I felt good about myself. I felt rejected or unwanted.
I felt unlovable. I did poorly in school. I was not allowed to cry.

I tried to be perfect. I had intense nightmares.

For the following, *circle* which words would make the statement true.

My mother/father was often or entirely absent.

My mother/father was often depressed/angry/anxious.

I was hospitalized for a serious illness/accident.

I was often ashamed of myself/my father/mother/family.

Put "M" for my mother and/or "F" my father (for all that apply) . . .

_____was abused or abandoned as a child. _____ was sometimes violent.

_____ suffered from physical illness. _____ suffered from alcoholism.

_____ suffered from mental illness. _____ attempted or committed suicide.

_____suffered from a drug problem. _____did not have any problems of which I was aware.

When I was a child, I was sexually molested by (circle those that apply) . . .

a playmate a friend my father my mother

my brother my sister another family member someone outside my family No one

In their order of entrance in your life (from first to last), who were the people by whom you felt loved? Name Relation to you

(1) _____ _____

(2) _____ _____

(3) _____ _____

(4) _____ _____

(5) _____ _____

(6) _____ _____

In their order of appearance in your life (from first to last), who were the people by whom you felt hurt or

Harmed by?

Name Relation to you

(1) _____ _____

(2) _____ _____

(3) _____ _____

(4) _____ _____

(5) _____ _____

(6) _____ _ _____

What was your happiest experience as a child?

_____

_____

_____

_____

What was your most emotionally painful experience as a child?

_____

_____

_____

_____

PART III: SPIRITUALITY

What is your current religion or spiritual orientation?

_____

Is your spiritual orientation different from your families? Yes No

If yes, how is it different? _____

_____

_____

How frequently do you attend church or meet with others who share your spiritual interests?

_____

How frequently do you pray, meditate, or read spiritual material?

_____

Are you involved in any other religious or spiritual activities (volunteer work, an organized charity, etc.)?

_____

Whose deaths have touched you personally?

_____

Are you currently experiencing any difficulties or challenges in your spiritual life?

_____

_____

_____

PART IV: RECREATION

What are your favorite things to do for fun?

_____

_____

Are you now involved in any form of regular physical exercise or stretching?

Do you follow any particular dietary program? How would you describe your daily eating patterns?

What hobbies or activities do you *wish* you could explore or pursue?

If you were free to go anywhere and do anything you want, what would you do?